

**THE HEALTH of
NORTHAMPTONSHIRE
in 1963**

PART II

**Report of the
Principal School
Medical Officer**





TONGUE EXERCISES — THE SPEECH THERAPIST AT WORK

NORTHAMPTONSHIRE COUNTY COUNCIL
EDUCATION COMMITTEE

SCHOOL HEALTH SERVICE
ANNUAL REPORT
1963

Principal School Medical Officer:

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THE SCHOOL HEALTH DEPARTMENT,
GUILDHALL ROAD,
NORTHAMPTON.

April, 1964.

TO THE MEMBERS OF THE NORTHAMPTONSHIRE EDUCATION COMMITTEE

I have the honour to present my second report and the fifty-sixth annual report on the health of Northamptonshire schoolchildren.

This report follows the same form as that introduced last year and in its preparation I am most grateful for the help of my medical and dental colleagues who have supplied me with many of the facts and figures which it contains. I am also grateful to them and to my entire health visiting, clerical and other staff for their very considerable efforts during an extremely busy year.

One important development was the introduction of the county's audiology scheme, through which children are now being routinely tested to ensure that their hearing is satisfactory. In the past there is no doubt that some children suffering from partial deafness, usually to a restricted range of frequencies, have gone unrecognised and have been considered simply to be backward. Under the new scheme such children should be promptly detected and referred either for medical assistance or for special educational treatment should this prove necessary on account of hearing loss.

Another major event of which an account will be found in this report is the reorganisation of the School Health Service which was prepared during 1963 with a view to its implementation early in 1964. The object of this is to bring the service into line with modern requirements, with more attention being given to health education and to work with the small number of handicapped pupils, less time being spent on routine examinations, particularly in the intermediate age group. The importance of health education in children cannot be overstressed, for the good or bad habits formed in childhood are often those which persist throughout life. As will be seen from this report, attention has been paid not merely to traditional teaching on matters of hygiene, but also to such special problems as dental health, foot health, the dangers of cigarette smoking and the important subject of "growing up" both physically and mentally. In some of these activities attention has been focused, not merely on the children, but also on their parents, as without parental help and example health education is unlikely to prove as fruitful as it should be. This last point is of particular importance in relation to cigarette smoking and here parents have a clear moral responsibility.

The strengthening of the dental service during the year was most welcome and the employment of the county's first dental auxiliary proved to be a success. The Chief Dental Officer is to be congratulated on the results of his efforts to augment and develop this service, as dental neglect is still widespread throughout the community and a strong school dental service is essential if this state of affairs is to be overcome.

The Child Guidance Service, which is a joint one with the County Borough, continued to operate under difficulties caused by shortage of staff. The speech therapists, on the other hand, were at full strength and undertook a substantial amount of work during the year. The health visitors, in their rôle of school nurses, assisted in medical inspections as well as spending an increasing proportion of their time on the preventive and health educational sides of the School Health Service.

The year was sadly marred by the deaths of Miss W. M. Williams, Superintendent Nursing Officer and Dr. H. R. Simpson, Senior Medical Officer, to both of whom reference is made in Part I of the "Health of Northamptonshire for 1963".

In conclusion I would like to thank the Medical Inspection and Treatment Committee for its sympathy and encouragement throughout a period which saw substantial changes in the School Health Service.

I have the honour to be,

Your obedient servant,

J. J. A. REID,

Principal School Medical Officer.

SCHOOL MEDICAL INSPECTIONS

Introduction

During the year there were various changes and consequent temporary shortages of medical staff (to which reference is made in Part 1 of this report), and for this reason the number of schoolchildren examined fell by 2,584 to 12,630. Part of this decline was also due to a deliberate act of policy in reducing the number of cases seen by each medical officer during a morning or afternoon session at school. This reduction was made in order to permit doctors to give more time to children with handicaps or problems and to allow full discussion with their parents.

Elsewhere in this report there will be found a description of the revised School Health Service arrangements which are to come into operation in 1964, and this new scheme will depend upon medical staff having adequate time to devote to work with children who have particular physical or psychological problems.

The general physical condition of pupils remains satisfactory although, once again, members of the medical staff have drawn attention to the number of children who are overweight. Amongst other comments from school doctors are the following points which appear to be worthy of particular attention.

Dr. P. X. Bermingham refers to maladjusted children and those suffering from behaviour difficulties, and points out that these form a small but interesting section of pupils who require adequate time to be spent on them if they are to be fully investigated. With patience, and as a result of detailed discussions with parents, teachers and health visitors, it is amazing what can be brought to light, and the cause of the trouble, far from invariably being in the child, may well be with the parents, with the family group, or even with the school itself. He points out that although such cases take up considerable time, great benefit can be derived from a full investigation and an unhappy backward pupil may be turned into a happy member of the school with consequent improvement from the scholastic point of view.

Dr. Joan M. St. V. Dawkins also refers to the need to give more consideration to matters of mental health within the School Health Service rather than concentrating on the diminishing amount of physical trouble. She is particularly concerned about the need for preventive work and considers that the interdepartmental meetings to deal with problem families are a useful step in this direction. Once again Dr. Dawkins expresses disappointment in the choice of careers of many of the pupils whom she sees and wonders whether, in the past, adversity has acted as a necessary spur to the adventurous spirit. The modern teenager has now little hardship and the energy which robust physical health and a good home have supplied is often wasted in futile pursuits or used in a destructive manner sometimes ending in vandalism. High spirits engendered by good health perhaps need some form of channelling, and this task should be a joint responsibility of parents, teachers and the school health team.

Dr. J. V. L. Farquhar remarks upon the general good health of the schoolchildren seen by him, with the exception of prevalent dental decay, unsuitable styles of footwear, and a fair number of cases of obesity.

Dr. Muriel Goodchild is likewise concerned about the number of overweight children seen both at infant welfare clinics and in schools. She is interested in the background of such children and wonders whether a proportion are, in fact, suffering from various forms of anxiety for which they compensate by over-eating.

Dr. A. Lucas, like Dr. Dawkins, is surprised at the number of children who have no idea what they wish to do even a month before leaving school and who have not made any arrangements for obtaining jobs. He hopes that the projected extra year at school will help them in this decision, although he is not entirely convinced of its value.

Schools

The number of schools in the Authority's area at 31st December, 1963 was :

Primary	232
Technical	1
Grammar	9
Modern	31
Nursery	2
Special	4
	<hr/>
	279
	<hr/>

Total number of pupils on the registers at autumn term 1963 : **45,737**

Medical examinations

The pattern of physical defects found among the routine examinations for which treatment was needed is indicated in the table below :

<i>Defect</i>	<i>No. of defects requiring treatment (11,489 pupils examined)</i>	<i>Rate of defects ascertained per 1,000 children examined</i>		
		1963	1962	1961
Skin	56	4.87	7.06	7.75
Vision	550	47.87	50.06	40.16
Squint	26	2.26	3.82	3.35
Otitis Media	9	0.78	1.08	0.55
Heart and Circulation	10	0.87	1.33	1.05
Nose and Throat	117	10.18	11.31	9.7
Lungs	14	1.22	1.99	2.09
Developmental—hernia	9	0.78	1.08	0.77
—other	39	0.34	0.40	0.31
Orthopædic —posture.....	44	3.83	3.74	1.47
—feet	126	10.97	8.48	5.23
—other	49	0.43	0.67	0.57

The outstanding feature of this table is the paucity of serious physical defects which are found nowadays, with vision and diseases of the nose and throat (usually in the form of tonsil or adenoid troubles) playing major parts in many of those which still remain. The rising incidence of foot defects is disturbing.

A NEW APPROACH TO THE SCHOOL HEALTH SERVICE

During the past decade, increasing attention has been given both nationally and locally to the need for change in order to bring the whole concept of the School Health Service into line with the needs of today, which are radically different from those which applied when the Service came into being early in the present century. The following is taken from the report on the subject which was adopted by the Medical Inspection and Treatment Committee in September. The administrative side of the revised scheme was dealt with in the autumn and the whole plan should be brought into operation in the course of 1964.

Re-organisation of School Health Service

1. Introduction

The School Medical Service, as it was then called, was established over 50 years ago to deal with formidable medical problems. Gross ill-health was commonplace among children as a result of poor social conditions, ignorance, malnutrition, poverty and infectious diseases. The immediate objectives of the service were inevitably remedial and led to a pattern of work aimed at the detection of defects and the arranging of treatment.

The past half century has brought about a dramatic change in the health of schoolchildren. Social and environmental improvements have combined with medical progress to alter the whole pattern of health and disease in childhood. Today the major diseases of the past have almost completely gone and schoolchildren are taller, heavier and healthier than ever before.

2. Present problems in child health

Thus the conditions which led to the initiation of the school health service have passed into history and it is more than time for it to adapt itself to the needs of the present day for, despite the encouraging state of affairs outlined above, there are still many children who suffer from conditions liable to affect their health or to interfere with their education. These conditions include impaired hearing and vision, emotional and behaviour difficulties, and other physical and mental handicaps. The following figures for 1961 give some impression of the position:

	<i>England and</i>	
	<i>Wales</i>	<i>Northants</i>
Defective vision or squint	538,758	959
Ear, nose and throat conditions	133,780	606
Orthopædic defects	118,650	1,011
Emotional disturbances	46,350	214

Other factors, both medical and social, must also be remembered in relation to the present state of child health. One of these is earlier maturation ; today this is attained in girls at the average age of 13½, compared with 17 years at the beginning of the century, and this has happened during a time when the raising of the school leaving age has lengthened the period of dependency in adolescence. It is frequently alleged that there is evidence of increased sexual promiscuity amongst young people, and the schoolgirl mother is certainly not unknown. Another problem is the rise in delinquency in recent years, and here again there are medical, psychological and social factors involved. Such hazards as the 26,000 deaths per annum from lung cancer, mainly attributable to smoking, and the high incidence of foot deformities due to unsuitable shoes are likewise modern problems which must be tackled in childhood.

There thus remains much scope for the school health service but, if it is to succeed, it must adapt itself to modern conditions.

3. Aims of a modern school health service

The health of a child is primarily the responsibility of the parents and the family doctor. Since the introduction of the National Health Service any illness or defect, once discovered, can be promptly treated through the general practitioner or hospital services. The school health service is not in rivalry with these, but rather plays a complementary rôle. Fundamentally it has the aim of producing young adults whose physical and mental health is of the highest possible standard, providing an effective basis for a healthy, happy and long adult life. This target is well beyond the mere elimination of gross defects and is in fact an attempt to achieve not only the prevention of disease but also the promotion of a high standard of health. It is obviously impossible for one agency to achieve these objects working in isolation and, throughout the whole texture of a reorganised service, should run a strong thread of co-operation between all those concerned in the health of children.

An effective school health service must serve the following functions :

- (a) The assessment of the health of schoolchildren.
- (b) The ascertainment and care of handicapped pupils.
- (c) The promotion of health.

(a) ASSESSMENT OF CHILDREN

At present the basis of the school health service in Northamptonshire is the routine medical examination of children three times during their school lives. There are, it is agreed, two occasions in a child's school life when he undergoes major changes in his environment and when a routine medical examination is of value. These times are at school entry and just before leaving school.

- (i) *Entrant examination.* Although most children are seen by family doctors at some stage during the first five years of life, a large proportion enter school without having had comprehensive medical examinations. In view of the importance of good health to education, the examination of five-year-old children must be continued. It is important, however, to make these examinations comprehensive and satisfactory, and this can only be done by a system which encourages the attendance of parents, considers the opinions of school teachers and health visitors, and allows the doctors sufficient time to perform adequate examinations. These should provide the information regarding the children's health, background and character upon which their subsequent supervision can be based. The parents would be asked to complete detailed questionnaires concerning the children's health and medical histories and these would then be carefully considered by the school doctor and, if necessary, discussed further with the parents. Discussions would also take place between the school doctor, the health visitor and the school teacher. The initial health assessment on school entry would thus include full consultations as well as a careful examination.
- (ii) *Leaving examination.* By the time a child reaches the final stage in his school life, he will have been under the supervision of the school health service for a minimum period of almost 10 years. The final assessment of his health should be forward-looking and should provide medical advice to the parent, to the youth employment service and, of course, to the child himself, so that he can leave school with no defect still requiring remedy. At present only a minority of school leavers go to work with firms which provide occupational health services, and the school doctor, with his intimate knowledge of the child's health at school, is in a strong position to give advice for the continued promotion of health during late adolescence. Good relationships between the school doctor and careers teacher are necessary, as well as a close liaison with the youth employment service.

- (iii) *Intermediate examination.* The main proposed change in the present system consists of the replacement of the intermediate examination, which is at present carried out about the age of 10 years. Approximately three-quarters of the children examined at this stage have no defects and, of the remainder, many defects are already known and under treatment. The usefulness of this particular routine examination has, therefore, been challenged for many years and as long ago as 1953 the Ministry of Education indicated that it would consider suggestions from local education authorities for modifications in the system of inspections.

The Report of the Chief Medical Officer of the Ministry of Education covering the years 1960 and 1961 states that, at that time, 16 county boroughs and 12 counties had formulated schemes of selective examination, and that the results have been encouraging. The report adds that the most constant and important finding is the good teacher-doctor relationship which has been established.

The present system in Northamptonshire should be replaced by one in which more attention is devoted to those children who require it and, in order to achieve this, a selective procedure is required. This would again call for consultation with the parents, the teaching staff and the school nurse and the procedure would enable the medical officer to concentrate his efforts on those children who really require help and guidance rather than spending much time and energy on routine examinations of healthy children. This type of selective examination is working well in other parts of the country and, indeed, enhances the quality of the service. It has not been found to reduce the total amount of work done by the school doctor but has, in fact, usually increased it, as giving adequate time and attention to individual children with handicaps and maintaining close and continuous liaison with schools occupies more time than do routine intermediate examinations.

(b) THE ASCERTAINMENT AND CARE OF HANDICAPPED PUPILS

The most specialised work of the school health service lies in the care of handicapped children. The assessment of the degree of handicap and the proper educational placement of the child requires not only knowledge and experience on the part of the doctor, but the fullest amount of information from all sources. The basic aim in dealing with handicapped children is to afford them the highest opportunity compatible with their degree of handicap of living a normal life. In this important work the school doctor must bring the teacher into close consultation since, if the child is to remain in an ordinary school, it is the teacher who will shoulder the burden. The family doctor and the consultant paediatrician must also be made aware of what is happening, so that they can give any further advice or guidance which they wish the school medical officer to consider before making his recommendation. Hence frequent visits to schools, sound links with the education services and good liaison with other members of the medical profession are the basis of an adequate service. The present organisation of the school health service does not encourage such liaison, as the sheer weight of routine examinations constantly tends to preclude all else.

(c) THE PROMOTION OF HEALTH

A comparatively recent development in the school health service has been the realisation of the importance of the promotion of health as distinct from the detection of established disease. Such problems as cancer of the lung, deformities of the feet and certain forms of mental ill-health stem from faulty ways of living and it is clear that one of the best places to begin inculcating the principles and practice of healthy living is in the school.

Although much of this task falls to the teacher, the school health team of doctor and nurse can render valuable assistance by supplying advice and guidance, and indeed by themselves

giving talks on those subjects where their specialised knowledge would be of particular value. In recent years there have been encouraging signs that, in Northamptonshire, head teachers are increasingly aware of the help which they can receive in this way from the school health service.

Over the next few years, all aspects of health education in schools must be reviewed and extended, so that every increase in medical knowledge can be fully applied in the promotion of health and the prevention of disease. At the end of the next 50 years of the school health service it will surely be said that the main benefits have been derived from the development of a health education service for schools. This can be achieved by reorientating the service away from its traditional preoccupation with routine physical examinations.

4. The functions of a reorganised school health service

These may be summarised as follows :

(a) A ROUTINE MEDICAL EXAMINATION OF SCHOOL ENTRANTS. This would be a comprehensive examination supported by detailed information from the parents and with the opinions of teachers and school nurses at hand.

(b) A ROUTINE EXAMINATION OF SCHOOL LEAVERS. This would once again include the obtaining of information from parents as well as discussion between the school health team, the school staff and the youth employment officer.

(c) AN INTERMEDIATE MEDICAL ASSESSMENT. On the basis of information collected from parents and all other relevant sources, children would be chosen for medical examination by the school doctor. In order to allow sufficient time for the correction of any defects before the child enters the important stage of his education leading up to secondary school selection, the best time for this medical assessment would be about the age of nine years.

(d) ADEQUATE AND CONTINUOUS OBSERVATION. Throughout the whole of school life each child would be kept under observation by the school health team and examined whenever the school nurse, head teacher or parent requested it. In view of the importance of sight and hearing, screening tests for these would be done at various times during school life.

(i) *Vision*. This would be tested as soon as possible after entry to school, and at the ages of eight, 12 and 14.

(ii) *Hearing*. This would be tested by sweep audiometry at the age of six, and in addition, special "at risk" groups would be tested as and when required.

The head teachers and staff of all schools would be encouraged to bring forward for re-testing any children whom they suspect to be suffering from defects of sight or hearing.

(e) HANDICAPPED PUPILS. Particular attention must be paid to every child considered to be handicapped. In planning the work of school medical officers the ascertainment, care and supervision of handicapped children would be given high priority.

(f) IMMUNISATION. Arrangements would be made for all immunisations of schoolchildren to be kept up-to-date. This is an elementary precaution but one which has hitherto been inadequately taken because of sheer pressure of routine work.

(g) HEALTH EDUCATION. The staff of the school health service, in co-operation with the health education section of the County Health Department, would co-operate with the County Education Department and head teachers in developing an improved scheme for health education in schools. Both school medical officers and school nurses would be made increasingly available to give talks to pupils when requested.

(h) ADEQUATE LIAISON.

- (i) *With teachers.* The liaison with teachers would be based on regular visits to the school by the school doctor. At these visits the head teacher or any member of his staff would be able to bring forward the case of any particular child or to raise and discuss any matter relating to the wide field of child health. It would be general policy for as much information as possible to be passed on to the head teachers by the school health service and, following medical examinations, the school medical officer would complete a subsidiary record card containing any relevant information and recommendations. This card would then remain in school and be passed on to subsequent head teachers for their information as the child moved from junior to senior school. It is confidently anticipated that head teachers would co-operate in the spirit of these liaison visits, so that in time each school would feel that it had the personal interest of its own school doctor.
- (ii) *With parents.* The basis of this relationship would be laid when the child enters school. With the initial appointment and invitation to the parents to attend the medical examination of their child, would be included a leaflet outlining the aims of the school health service. Throughout the school lives of children, their parents would be encouraged to feel that they had every opportunity to approach the school medical officer or school nurse on any matter on which they might be of help. Before the medical examinations of entrants and school leavers and also when their children reached the age of nine, parents would receive questionnaires which, as well as asking for information about the histories of their children, would also include the offer of an appointment for consultation. During the process of ascertainment every effort would be made to keep parents fully informed, and any recommendation made by the doctor would be explained. In these ways it is hoped that parents would realise that, in the school health service, they could find the special help and guidance which might be necessary to ensure that their children are as well prepared as possible for their school and future lives.
- (iii) *With family and hospital doctors.* Co-operation with family and hospital doctors would be based on the realisation that each has a part to play in child health. At the present time there are good relations between the service and these doctors, and it is almost always possible to obtain from them any information regarding hospital or domiciliary treatment which is required. On the part of the school health service, this co-operation would be improved by guaranteeing to keep the family doctor or consultant informed of the results of any special investigations carried out, such as intelligence testing or audiometric examination.

HEALTH EDUCATION IN SCHOOLS

There has been a welcome growth in the interest of teachers and pupils in the teaching of health matters in school by members of the school nursing and medical staffs. In an increasing number of schools this teaching has taken the form of regular classes conducted by school nurses and particular attention has been given to a course under the heading " Growing Up ". This is now part of the permanent timetable in three secondary schools and, in a further three, the programme is gradually being introduced. One headmistress has reported that her staff has remarked on the change of attitude and appearance in the girls who have had the benefit of this health teaching. The syllabus of the course on " Growing Up " is as follows:

1st meeting	Leisure pursuits
2nd meeting	Leisure pursuits
3rd meeting	Development
	Boy and girl friendship
4th meeting	Physical development
	Emotional development
5th meeting	Courtship
	Engagement
	Physical attraction
6th meeting	Preparing for marriage
	Home making
	Hire purchase
7th meeting	Marriage
	Give and take
	To work or not to work
	Housing
	Saving
8th meeting	Social services
	What we pay and what we get
9th meeting	The family responsibilities
	How the local authority helps
	Community help
10th meeting	Question time

It will be seen that the syllabus is a wide one and pays attention to many aspects of growing up. It certainly does not confine itself to matters of so-called sex education. This is a deliberate policy as the tendency to separate sex education from all other aspects of education for living is to be deprecated. It is important that children should realise that sex is only one factor of many in life and that appropriate sexual behaviour cannot be separated from more general questions of behaviour and of responsibility.

In addition to this general syllabus of health teaching, school nurses are called upon to give a variety of talks to classes of all ages. Attention has been focused on several particular problems and reference is made elsewhere in this report to attempts which are being made to interest parents and children in appropriate forms of footwear. An even more important subject is that of cigarette smoking in relation to health. In April, a mobile anti-smoking unit of the Central Council for Health Education visited the county and was received with an official welcome at Rushden Clinic attended by members of the County Council. Ten secondary schools, five grammar schools, and several youth clubs and voluntary organisations were visited. At the same time posters and leaflets were sent to every junior and senior school in the county and the press gave remarkably good coverage, thus helping to draw general attention to the problem.

No country can afford to lose tens of thousands of its citizens every year from diseases directly due to cigarette smoking and it is to be hoped that attempts at enlightenment will spread to parents as well as to children, as it is a waste of time to inform the latter that they should not smoke when the example of their parents points in the opposite direction.

An attempt was made to evaluate this anti-smoking campaign by asking for the opinions of head teachers from the schools which took part. Their response tended to be rather pessimistic but several points emerged. In the first place, the lectures given by the members of the mobile unit were well planned and suited to the age groups concerned. Secondly, it was felt that, whilst the immediate effect was powerful, there was a danger that it would not last for very long. Finally, it seemed clear that the campaign would require to be followed up at regular intervals if lasting benefits were to ensue and an attempt will be made to do this with the co-operation of a group of head teachers.

The major event in the diary of the County Health Department during 1963 was the Northamptonshire Mental Health Project and, in connection with this, a one-day conference on "Mental Health in Schools" was arranged in October at Knuston Hall. Forty-seven head teachers attended and a comprehensive programme of films and lectures was followed by a panel discussion. The opinions expressed by many of the participants indicated that they were well aware of the problems of mental health peculiar to schoolchildren. Arrangements were also made for certain children to visit St. Crispin Hospital.

When the revised system of selective medical examination comes into operation in the county, still greater emphasis will be placed on health education as this, almost more than any other aspect of the School Health Service, can help to ensure that the coming generation will grow up adequately informed on matters which will effect their own health and, in the fulness of time, that of their children.

HANDICAPPED PUPILS

Educationally Sub-normal. One hundred children were examined following reports from head teachers and school doctors of failure to maintain progress in school.

The following recommendations were made by the medical officers :

Admission to a day or boarding special school	68
Report to the Local Health Authority as unsuitable for education at school (Education Act, 1944, Section 57)	16

At the end of the year 208 children had been ascertained and were awaiting admission to day or boarding schools for educationally sub-normal pupils. Of this number, the parents had refused the offer of places in 64 cases. Two hundred and twenty children were receiving education in special day or boarding schools.

Blind. One pupil was admitted to a special school. There are, at present, seven pupils in special schools for the blind.

Partially Sighted. One pupil was admitted to a special school. Fourteen partially sighted pupils are now being educated in such schools.

Deaf. Two pupils assessed during the year as needing special educational treatment at special schools were so placed, together with a third child assessed the previous year. At the end of the year 13 pupils were in boarding schools.

Partially Hearing. One pupil, assessed during the year, was placed in a special school and seven pupils are now receiving boarding education under this category.

Physically Handicapped. Eight children were ascertained and eight were admitted to special schools. At the end of this year 31 physically handicapped pupils were receiving special educational treatment, including 21 at Kingsley Special School.

Delicate. Nineteen pupils were reported and 14 were admitted to special schools. At the end of the year 40 pupils were in special schools, 29 of them in the Physically Handicapped Department of Kingsley Special School.

Maladjusted. Thirty-one pupils were assessed as needing educational treatment at special schools or in boarding homes, and 16 were placed during the year. At 31st December, 21 children were in hostels and 12 in boarding special schools.

Epileptic. One pupil was admitted to a boarding special school as an epileptic. Four pupils were receiving such education at the end of the year.

DEFECTIVE VISION

A total of 2,719 examinations or re-examinations were carried out and 1,332 pairs of spectacles were prescribed as the result of refractions performed by ophthalmologists who were made available by the Oxford Regional Hospital Board.

The administrative side of this work has been altered so that when a case is referred for refraction a letter is sent to the parents offering an appointment at a school eye clinic, but the child's name is not entered on the waiting list until after the receipt of a reply-paid postcard indicating that treatment is desired through School Health Service arrangements. In the past a proportion of appointments have not been kept because some parents have preferred to make their own arrangements without indicating that they had done so. This resulted in considerable waste of ophthalmologists' time and, under the new system, by December the number of children

awaiting appointments had fallen to 530, compared with 1,000 a year earlier. This revised waiting list offers no scope for complacency but at least gives a more accurate picture of the situation.

Colour Vision Testing. At the request of head teachers or parents the school nurses carried out 762 colour vision tests at school leaver examinations. Sixty-three of these pupils were referred to the school doctors who confirmed some degree of colour blindness.

AUDIOLOGY SERVICE

The county's audiology service was initiated in January with the appointment of Miss B. P. Joyce, S.R.N., as audiometrician. Following her initial period of training at the Ear, Nose and Throat Department of Northampton General Hospital (by kind arrangement with Mr. Charles Gledhill) she began her work by testing the hearing of all six year old children, and every school containing infants had been visited by the late summer. The object is to test the hearing of these children in order to detect any hearing loss which may not have been recognised by the parents or teachers, yet which may be sufficient to cause educational retardation. Each child is tested by a transistor pure tone audiometer at frequencies of 500, 1,000, 2,000 and 4,000 cycles per second. As a result of this test, any child with a constant hearing loss of 30 decibels in one or both ears is referred to a hearing assessment clinic.

When the scheme was first introduced it was under the medical supervision of Dr. H. R. Simpson, Senior Medical Officer, who also conducted the assessment clinics. Following his death, the work was taken over by Dr. F. R. N. Lynch and acknowledgement must be made of his great help in running the medical side of the scheme and in preparing the material for this report.

The audiometrician tests 40 to 50 children in a session and also meets requests for special tests in the case of pupils referred by school medical officers, family doctors and teachers. The latter have been most co-operative and appear to have found the audiometric service helpful.

Approximately 6,000 children in the six-year old group were tested and, as a result of these tests, 395 (6.58%) were referred to the assessment clinics which are held in various convenient centres throughout the county, special transport arrangements being made for the children where necessary. At the assessment clinic a more extensive investigation of hearing is made by means of a diagnostic pure tone audiometer and a clinical examination is carried out by the medical officer. Obvious causes of deafness such as wax, infected or enlarged tonsils and adenoids are dealt with either by instructions to the parent or by referral to the ear, nose and throat surgeon. The more obscure causes of hearing loss and those cases in whom the deafness is considered to be due to catarrhal conditions are usually reviewed after a suitable interval when, if the condition still requires to be pursued, the child is referred to a specialist who then has the advantage of seeing the two earlier audiograms. The family doctor is always consulted before such referrals and, by the end of the year, approximately 100 children had been referred for treatment.

During the severe winter of 1962/63 a relatively high percentage of children were suffering from temporary catarrhal deafness and the majority, on retesting in the summer, were found to have normal hearing. This contributed to the delay in getting children to assessment clinics and it is hoped that the waiting list will diminish in the coming year.

At the end of 1963 a special survey showed that there were 36 children in the county who were not attending special schools yet who used hearing aids, three of these having been discovered as an outcome of the audiometric service. These three had not been suspected of

deafness and two had learned to cover up their difficulty and apparently adapted themselves by means of lip reading. Without the audiometric service they might well have continued through life with only partial hearing and without anyone realising the full extents of their handicap. It is confidently hoped that, as the service becomes an established part of school medical work, this state of affairs will not arise in the future.

FOOT DEFECTS

The problem of foot defects caused by the wearing of unsuitable shoes has caused concern in all members of the school medical and nursing staff for some time and this subject has been mentioned in previous reports. In September, a circular was sent to the head teachers of secondary schools in the following terms :

- “ Increasing concern is being felt by the Medical Inspection and Treatment Committee and by the Principal School Medical Officer and his staff about the problem of foot defects in children and particularly amongst older schoolgirls. By the time many of these children leave school they have deformities of the feet, usually in the form of displaced big toes with consequent overcrowding of the other toes and resultant bunions and corns.
- “ If disorders of this kind are not corrected they lead to troublesome and disabling conditions in later life. The cause of most of these defects is the wearing of shoes which are unsuitable in size, fitting or style, and amongst senior girls this presents particular difficulties. Many factors are involved in the present state of affairs, but fashion and group pressures towards conformity are the main culprits. The solution to the problem can lie only in long-term health education, and both parents and the children themselves must be persuaded of the importance of healthy feet.
- “ Talks on foot health are already being given by health visitors in the course of their work in schools and their efforts are supplemented by the use of film strips, pamphlets and other visual aids material. It is hoped that these efforts will be continued and expanded, and if any head teacher desires help in this respect it will be readily made available.
- “ While this approach through health education must continue for many years to come, there is another approach which might commend itself to head teachers and to school governors. This is to specify a suitable pattern of shoe as part of the school uniform. This would not overcome difficulties caused by poor fitting, but would, at least, prevent damage resulting from extremes of fashion. Enclosed is a pamphlet dealing with the selection of suitable shoes for children and, should you desire any further information, we should be pleased to supply it.”

The pamphlet to which reference is made is issued by the Shoe and Allied Trades Research Association, and is an excellent publication. A debt is due to the recently retired Director of the Association, Mr. H. Bradley, for the help and advice he has given on this subject.

DIABETIC CHILDREN

In the report for 1962 reference was made to the special school meal arrangements which are made for diabetic children. At lunch these children usually receive a modified main course and a substitute for the sweet course while, in some instances, arrangements also have to be made for them to receive snacks during the morning or afternoon. In the hope that these comments aroused interest in the subject of diabetic children, a wider account will now be given of their care from the point of view of the School Health Service.

At the end of 1963 there were in Northamptonshire 33 diabetic children of school age, and all but two of these were making satisfactory progress in ordinary schools. Diabetes mellitus is a relatively uncommon disease in children and is usually diagnosed promptly as its symptoms come on with considerable severity in their age group. It has sometimes been suggested that it would be advantageous if all children were to have their urine tested in the course of routine school medical examinations, as the presence of sugar in the urine is one of the principal signs of diabetes. The consensus of medical opinion, however, is that there would be little point in such tests because they would yield positive results only if the child was actually passing into the diabetic state, by which time he would almost certainly have marked symptoms of the disease and would, in all probability, already have been brought to medical attention. In addition, as diabetes comes on with such dramatic suddenness in children, it would be possible to test a child's urine one week and to find that only weeks, or even days, later he had developed diabetes. Under these circumstances it might even give a feeling of false security if the parents had been told, as the result of a urine test, that the child was not diabetic.

The diabetic child spends the major part of his life in school and diabetic care can be complete only if the school medical service is aware of his condition and progress. For that reason it is particularly important that copies of all letters from diabetic clinics to family doctors should be sent to the Principal School Medical Officer. This enables his medical staff to be fully informed when they are called upon to give advice on the care of diabetic children at school. In Northamptonshire it also ensures that such children can be brought to the notice of the health visitor who specialises in diabetic aftercare and to whose work reference is made in Part I of "The Health of Northamptonshire in 1963". It is also desirable that school teachers who are concerned with diabetic pupils should have some understanding of the disease in order that they may appreciate the importance of regular meal times; that they may know how to give first aid in the event of the child's insulin overacting; and in order that they may help diabetic children to lead as normal school lives as possible. In this connection it is important that the children should take part in all activities and should not use diabetes as an excuse for escaping from awkward situations because, with adequate insulin and a proper diet, the diabetic child should be able to lead virtually a normal life.

As the diabetic children in Northamptonshire are scattered throughout the county, it is understandable that they should, on occasion, feel isolated and unlike their classmates, as many of the pleasures of eating are forbidden to them. In order to help them to overcome such feelings and to give them confidence in dietary matters as well as in insulin injections, the British Diabetic Association runs summer camps for children, with expert medical and nursing supervision. Attendance at such camps is a most important part of education in its widest sense and the Medical Inspection and Treatment Committee make grants to permit children to attend these. During 1963, six attended camps in various parts of the country and all benefited from their attendance.

When diabetic children require special education it is almost always because of difficulties in their social environment and their needs are met by providing them with accommodation in a suitable hostel from which they attend the appropriate variety of ordinary school. One Northamptonshire girl was in such a hostel run by London County Council and, towards the end of the year, it seemed probable that at least one more child would benefit by admission to that type of accommodation.

The Principal School Medical Officer was invited to write an article on diabetic school-children for "Balance", the Journal of the British Diabetic Association, and this is reprinted as an appendix to this report (page 36).

ENURESIS CLINICS

In the last report an account was given of the first year's operation of the Corby enuresis clinic. This has continued under Dr. Goodchild and the work can be summarised as follows:

New cases seen	23
Re-visits to the clinic	44
Number of pupils who had use of alarm bell	27
Alarm bells on loan on 31st December	7
Number cured :	
(a) following use of alarm bell	9
(b) without recourse to bell	15
Referred to Pædiatrician	1
Number under treatment at end of year	27
Number on waiting list	3

A second enuresis clinic was opened by Dr. Dawkins at Daventry in October after consultation with family doctors and pædiatricians. As in the Corby clinic, a full case history is taken and a medical examination is carried out on each child. A laboratory examination of the urine is made. The patient is always accompanied by a parent and, should any organic or psychiatric pathology be suspected, the child is referred to the appropriate specialist with the consent of the family doctor.

The aim of treatment is to establish the cause of the enuresis and to give supportive therapy with the co-operation and interest of both the child and the parent. In some cases simple measures such as careful instruction and the keeping of a calendar by the child are sufficient, but the majority require help from an enuresis alarm and this is usually supplied on the second or third visit to the clinic. Successful mechanical treatment depends on parental co-operation and an efficient alarm, so the parent is carefully instructed in the operation of the machine and the school nurse visits the home during the first or second week after the apparatus has been supplied. The ultimate object is to make the child responsible for the management of the machine and to co-operate and accept treatment without fear or resentment. In certain deep sleepers a small dose of amphetamine may be necessary in order to lighten the sleep.

At Daventry only three clinics have so far been held and 14 patients seen. Of these, 13 were referred by health visitors and one by a school medical officer. Two children have been discharged as apparently cured but will be followed up to ensure that this is, in fact, permanent. One has been temporarily discharged as it was considered that failure of parental co-operation made attendance at the clinic a waste of time. Once again the situation in this case will be kept under review.

SPEECH THERAPY

This report has been compiled from notes supplied by the senior speech therapist, Mrs. M. G. Cunningham.

There has been a steady increase over the past ten years in the number of children receiving speech therapy. In 1953, when one speech therapist was employed, 165 children were treated whereas, in 1963, when the number of therapists had risen to four, 947 children received treatment. This increase does not mean that there are more children with speech defects than there were ten years ago, but rather that there is a growing awareness of the value of speech therapy, especially among teachers. During 1963, head teachers referred 307 of the 479 children who were recommended for therapy. These, and other statistics for the year, will be found in Table A.

As usual more children were treated for dyslalia than for any other defect (see Table B), with stammerers forming the second largest group. The apparent sudden increase in dyslalic children from the pre-school age to the infant school group, shows that insufficient is being done to help the pre-school child, as dyslalia is a developmental defect, not an acquired one, and must therefore be present in large numbers of pre-school children. The age for laying down the correct articulatory patterns starts at about one year and, although not fully complete until seven years, the great majority of children have established good patterns of speech by three or four years of age. If this has not happened the child should be treated as soon as possible and certainly long before the age of seven years.

A difficulty confronting the speech therapists (as will be seen from Table C) is that there are insufficient clinics in which to treat pre-school children and, in most cases, the children have to wait until they can start school before receiving treatment. Speech therapy in schools is far from satisfactory and, as more children are referred each year, the problem is an increasing one. The senior speech therapist is concerned at the number of children who are referred from the junior and senior schools by teachers and doctors and would like to see all articulatory defects referred as soon as they are noticed and never later than the first year at school. Apart from stammering and hysterical disorders, which can arise at any age, there is almost no chance of a child correcting his speech himself or "growing out of it" without help once he is over seven years of age. To delay obtaining help means that the bad articulatory habits become more firmly established and more difficult to change, especially as the older child realises much more than the young one that his speech is not acceptable, a realisation that often results in psychological stress. It is accordingly desirable that all teachers, school doctors and nurses should refer children with possible speech difficulties to the therapists as soon as possible.

TABLE A

Speech Therapy Statistics

No. of patients seen in year	947
No. of patients on register at 31st December	608
No. of patients discharged	339
Reasons for discharge :	
Normal or improved speech	245
Unable to help further	19
Unco-operative or failed to attend.....	30
Left school or district	45
No. of patients referred and not admitted	22
No. of patients on waiting lists at 31st December	53
No. of new patients referred during the year	479
by school doctors	60
by head teachers	307
by health visitors	49
by parents	16
by others	47
No. of attendances in the year	8686
No. of pre-school children treated in the year	37

TABLE B
Analysis of Speech Disorders

	<i>Dyslalia</i>	<i>Dysarthria</i>	<i>Cleft Palate</i>	<i>Stammer</i>	<i>Stammer and Dyslalia</i>	<i>Dysphonia</i>	<i>Development and Aphasia</i>
Pre-School Child	19	—	—	1	1	—	9
Infant School	204	2	3	18	11	5	16
Junior School	151	5	4	46	6	—	4
Senior School	20	2	2	19	3	3	—
Special School	30	2	1	1	2	1	6
Total	424	11	10	85	23	9	35

Not included above :

Dyspnœa, 7

Idioglossia, 6.

Anarthria, 1

Undiagnosed pre-school child, 1.

TABLE C
Distribution of Patients, showing where they were Treated

<i>% of patients treated in 1963 at :</i>	<i>Wellingborough R.D. Thrapston R.D.</i>	<i>Kettering R.D. Brixworth R.D.</i>	<i>Brackley R.D. and (South) Towcester R.D.</i>	<i>Northampton R.D. Daventry R.D. (North) Towcester R.D.</i>	<i>Corby Dist. and Oundle R.D.</i>
School ...	51.8%	85.3%	98%	72%	78%
Clinic ...	47.0%	13.7%	—	27%	21%
Home ...	1.2%	1.0%	2%	1%	1%

INFECTIOUS DISEASES

The procedure whereby head teachers report outbreaks of only five infectious diseases, namely diphtheria, poliomyelitis, dysentery, infective hepatitis and German measles, has continued. While this is the general procedure, head teachers are encouraged to consult the Principal School Medical Officer should they be concerned about any type of medical problem.

In the case of German measles, the district nurses continued to visit the mothers of all child cases reported because of the dangers from this disease to non-immune mothers in the first 12 weeks of pregnancy. During the year 105 notifications involving 396 children were reported by head teachers.

In the Report of the Chief Medical Officer of the Ministry of Education for 1960 and 1961, mention is made of a study of this subject in which it was found that 16% of children born to mothers who had the disease during this early period of pregnancy suffered from various congenital defects such as heart lesions, cataract, deafness and mental retardation, compared with only 2.3% in a control group.

The Chief Medical Officer points out that, in March 1961, there were some 50,000 married women of child-bearing age engaged in teaching. The report goes on: "School staff as well as parents of pupils should be informed when cases of rubella arise and should also be advised of the risks. Some authorities allow female staff in the first four months of pregnancy to remain off duty on full pay while the risk of infection lasts, or arrange for their transfer to an alternative school, or other establishment, until the normal place of employment is free from infection. This is a reasonable procedure, in the circumstances, and is commended to all authorities."

The Education Committee has agreed that, at schools where cases of rubella arise, female staff in the first four months of pregnancy shall, subject to the concurrence of the Principal School Medical Officer, be transferred temporarily to other schools or alternatively, be given leave of absence on full pay so long as there is a risk of infection.

Two cases of infectious disease reported during the year call for special mention. The first was a girl who contracted a paratyphoid infection. Her sister was excluded from school and special precautionary measures were advised. No further cases occurred among schoolchildren. The second case was that of a boarder at a boys' Grammar School who developed meningococcal meningitis. Fortunately he made a good recovery and measures were successfully applied to prevent the spread of infection in the school.

Tuberculosis. Four cases of respiratory tuberculosis and one of non-respiratory tuberculosis were notified. All the children were at separate schools, and their ages ranged from eight to 14 years. At one school, where an eight year old boy was found to be suffering from tuberculous pleural effusion, the staff were X-rayed and 86 pupils were Heaf tested and, at an infant school where a teacher was found to be suffering from respiratory tuberculosis, 34 children were similarly tested. In neither of these schools were any other cases of tuberculosis found.

B.C.G. Vaccination. Consent for Heaf testing and vaccination were obtained for 2,921 children, an acceptance rate of 98.2%. Six hundred and eight children (23.2%) were positive. The number of children vaccinated was 2,012, of whom 284 attended independent schools, and a total of 70 sessions were held by medical officers.

Positive reactors to the tuberculin test were offered chest X-ray examinations as recommended by the Tuberculosis Vaccines Clinical Trials Committee of the Medical Research Council. Of 619 children examined at the No. 1 Unit of the Oxford Regional Hospital Board Mass Radiography Service, five were referred to the Chest Clinic with the following results:

	<i>M</i>	<i>F</i>
Primary pulmonary tuberculosis (newly discovered) requiring close supervision	1	1
Healed primary pulmonary tuberculosis	—	1
Pneumonitis	1	—
Normal	—	1

DENTAL HEALTH

Report by P. W. GIBSON, L.D.S., Chief Dental Officer

The staffing position has again fluctuated during the year with a consequent effect upon continuity of inspection and treatment, and we may count ourselves fortunate in continuing to enjoy the services of a hard core, albeit a small one, of five full-time officers who have once again borne the brunt of the routine work completed in 1963.

On 1st January the staff consisted of five full-time dental officers and three part-time (with a full-time equivalent of one). By the beginning of the second quarter of the year the full-time equivalent of part-time dental officers had fallen to 0.7 and the position remained thus until the final quarter, when a new full-time dental officer was appointed as well as an additional part-time, and our first dental auxiliary also commenced duties. The staffing position in September was thus six full-time dental officers, one auxiliary, and three part-time officers (equivalent to one whole-time). In November a further full-time officer was appointed to commence in February 1964, and a second auxiliary was chosen to begin work in September 1964, bringing prospects of having the staffing figures at their highest level on record.

Despite the reduced staff available for a large part of the year, the statistics show a slight rise in the number of children inspected in school compared with 1962, and a continued fall in the number of children seen as "specials". It is very satisfactory to report an increase of approximately one and a half thousand in the number of fillings completed.

It would seem that the policy of providing good clinics with a high standard of equipment together with a happy working atmosphere has begun to pay dividends, and one can only hope that further progress in recruiting full-time dental officers to the staff will be possible in the coming years, as to date this county's dental service can only claim to have met approximately half of its commitments. Plans are in hand to equip a much needed second surgery in Northampton and it is hoped that this will be in operation at the beginning of February. A second surgery, for a dental auxiliary, will be provided in Corby as soon as arrangements are made to rehouse the Training Centre at present in Rockingham Road Clinic.

The decision to appoint a dental auxiliary from the training hospital at New Cross as part of the Ministry of Health's experimental scheme has proved successful. These girls are obviously very well trained and, within the limits of their clinical abilities, carry out work of a high order. The presence of young and personable girls to cope with the problems of handling very young children in the dental surgery is going to prove a very useful adjunct to local authority dental services.

Interest in dental health and care of teeth is growing slowly, and it is hoped that present dental health education projects on radio, television and in written publications will increase in scope and number, as the bombardment of injurious advertising material goes on unremittingly and apparently irresponsibly.

I would like to thank my clinical staff for their continued support during this year, and to express my appreciation of their assistance to Drs. Lilly, Maxim, Ward and Robertson, who have acted as anaesthetists. My thanks also go to those members of the clerical staff who have as usual, coped well with a multitude of problems in addition to routine work.

CHILD GUIDANCE SERVICE

Based on a report by DR. K. STEWART, Consultant Psychiatrist

In September, 1963, Dr. T. C. Waters, Registrar in Psychiatry at St. Crispin Hospital, joined the staff of the Child Guidance Service on a part-time basis. Mr. E. S. Dallal left and his place as Assistant Educational Psychologist was taken by Mr. V. M. Crowley. The third psychologist who should have been appointed was unfortunately not forthcoming owing to lack of response to advertisements. This means that the psychologists' time at the clinic is still the equivalent of only two-thirds of a whole-time appointment for the combined County and County Borough as the remainder of their time is taken up with duties in connection with the School Psychological Service.

Unfortunately it has not proved possible to obtain a further social worker despite repeated advertising and Mr. Payne still carries out his sterling work unaided. It will therefore be seen that meeting the requirements of the clinic is growing more and more difficult.

Statistics. The number of cases referred during the year has remained virtually unaltered, but the proportion of those requiring a longer time spent on them was higher with a consequent lowering in the number of new cases who could be seen. As a result the number of children waiting to be seen at 31st December was 87, this figure being nearly $2\frac{1}{2}$ times that of the corresponding one for the previous year. The waiting period for new cases has accordingly risen tremendously which is a most unsatisfactory state of affairs for children, parents, school medical officers, and general practitioners alike. It seems clear that unless more manpower of all kinds is available in the clinic this trend is likely to increase.

The remarks made in the 1962 report on the placement of children who require to be away from home still apply, and obtaining accommodation for these emotionally disturbed children is very difficult. It should also be noted that the educational and preventive work, which should be an important part of clinic activity has, of necessity, been kept to a minimum, although several discussion meetings have been held with school nurses and medical officers.

It is my pleasure to acknowledge the willing and loyal co-operation of the clinic staff.

MEDICAL EXAMINATION OF TEACHERS

The medical staff examined 230 candidates for admission to teachers' training colleges and to the teaching profession. None was classified as medically unfit to teach.

MEDICAL EXAMINATION OF CHILDREN IN PART-TIME EMPLOYMENT

One hundred and five children who were in part-time employment were examined by the school medical officers. In no case was it considered that such employment would be prejudicial to health.

SCHOOLS MEALS SERVICE AND THE MILK IN SCHOOLS SCHEME

The Chief Education Officer has kindly supplied the following figures relating to the school milk and meals service :

School Meals Service

	<i>October, 1963</i>	<i>October, 1962</i>
Number of Canteens and Dining Centres.....	212	213
Number of Primary and Secondary school children taking midday meal daily	19,510	18,715
Percentage of Primary and Secondary school children taking meals	45.43%	43.99%

Milk in Schools Scheme

Percentage of children taking milk :		
Primary and Secondary Schools	81.04%	82.61%
Nursery Schools	100%	100%

TABLE I
Periodic Medical Inspections

<i>Age Groups Inspected (By year of birth)</i>	<i>No. of Pupils Inspected</i>	<i>Physical Condition of Pupils Inspected</i>			
		<i>Satisfactory</i>		<i>Unsatisfactory</i>	
		<i>No.</i>	<i>% of Col. 2</i>	<i>No.</i>	<i>% of Col. 2</i>
		(3)	(4)	(5)	(6)
1959 and later	47	45	95.74	2	4.26
1958	1309	1304	99.62	5	0.38
1957	2734	2726	99.71	8	0.29
1956	575	569	98.96	6	1.04
1955	264	264	100	—	—
1954	250	249	99.60	1	0.40
1953	622	619	99.52	3	0.48
1952	2142	2120	98.97	22	1.03
1951	960	952	99.17	8	0.83
1950	277	277	100	—	—
1949	937	932	99.46	5	0.54
1948 and earlier... ..	1372	1367	99.64	5	0.36
Total ...	11489	11424	99.43	65	0.57

TABLE II
Other Inspections

A special inspection is one that is carried out at the special request of a parent, doctor, nurse, teacher or other person.

A re-inspection is an inspection arising out of one of the periodic medical inspections or special inspections earlier in the year.

Number of Special Inspections	...	...	...	1,129
Number of Re-inspections	...	...	...	12
Total	...	...	...	1,141

TABLE III
Return of Defects found by Medical Inspection
Periodic Inspections

Defect Code No. (1)	Defect or Disease (2)	Entrants		Leavers		Others		Total	
		(T) (3)	(O) (4)	(T) (5)	(O) (6)	(T) (7)	(O) (8)	(T) (9)	(O) (10)
4	Skin	13	43	24	34	19	74	56	151
5	Eyes—(a) Vision	161	500	138	100	251	198	550	798
	(b) Squint	19	38	1	5	6	21	26	64
	(c) Other	1	10	5	7	7	16	13	33
6	Ears—(a) Hearing	5	70	2	6	9	37	16	113
	(b) Otitis Media	3	101	4	6	2	46	9	153
	(c) Other	—	22	4	1	5	7	9	30
7	Nose and Throat	46	796	28	34	43	278	117	1108
8	Speech... ..	33	102	—	10	13	25	46	137
9	Lymphatic Glands	1	308	1	1	3	48	5	357
10	Heart	2	55	4	18	4	35	10	108
11	Lungs	4	134	4	29	6	65	14	228
12	Developmental—								
	(a) Hernia	7	8	—	3	2	6	9	17
	(b) Other	4	168	1	11	34	142	39	321
13	Orthopædic—								
	(a) Posture	6	83	19	29	19	96	44	208
	(b) Feet	77	126	16	27	33	85	126	238
	(c) Other	17	130	16	47	16	115	49	292
14	Nervous system—								
	(a) Epilepsy	7	14	4	10	4	17	15	41
	(b) Other	2	36	2	8	7	29	11	73
15	Psychological—								
	(a) Development	3	148	1	60	4	159	8	367
	(b) Stability	4	66	1	14	1	64	6	144
16	Abdomen	3	33	2	2	3	34	8	69
17	Other	6	40	14	18	14	53	34	111

T=Requiring treatment, or already under treatment.

O=To be kept under observation.

TABLE IV
Return of Defects found by Medical Inspection
Special Inspections

<i>Defect Code No. (1)</i>	<i>Defect or Disease (2)</i>	<i>Pupils requiring Treatment (3)</i>	<i>Pupils requiring Observation (4)</i>
4	Skin	9	56
5	Eyes—(a) Vision	99	191
	(b) Squint	9	13
	(c) Other	3	7
6	Ears—(a) Hearing	8	29
	(b) Otitis Media	3	38
	(c) Other	—	3
7	Nose and Throat	25	233
8	Speech... ..	17	44
9	Lymphatic Glands	3	71
10	Heart	7	54
11	Lungs	8	91
12	Developmental—		
	(a) Hernia	2	12
	(b) Other	24	113
13	Orthopædic—		
	(a) Posture	14	61
	(b) Feet	27	69
	(c) Other	3	69
14	Nervous system—		
	(a) Epilepsy	6	19
	(b) Other	2	28
15	Psychological—		
	(a) Development	3	156
	(b) Stability	2	62
16	Abdomen	1	22
17	Other	9	32

TABLE V

Pupils found to require treatment at Periodic Medical Inspections

(including those already receiving treatment, but excluding dental diseases and infestation with vermin)

<i>Age Groups Inspected (By year of birth)</i> (1)	<i>For defective vision (excluding squint)</i> (2)	<i>For any of the other conditions recorded in Table III</i> (3)	<i>Total individual pupils</i> (4)
1959 and later ...	—	2	2
1958	45	80	120
1957	104	131	225
1956	12	19	30
1955	15	10	25
1954	6	16	21
1953	34	46	78
1952	143	116	255
1951	43	56	92
1950	13	18	31
1949	51	54	103
1948 and earlier...	84	76	153
Total	550	624	1135

TABLE VI

Handicapped Pupils requiring Education at Special Schools or Boarding in Boarding Homes

(From Chief Education Officer's Return to Ministry of Education)

During the calendar year ended 31st December, 1963	(1) Blind (2) Partially sighted		(3) Deaf (4) Partially hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally sub-normal		(9) Epilep- tic	(10) Speech Defects	TOTAL Cols. 1-10
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes? ...	—	—	2	1	8	19	31	68	1	—	130
B. (i) of the children included at A, how many were newly placed in special schools (other than hospital special schools) or boarding homes? ...	—	—	2	1	6	13	11	18	1	—	52
(ii) of the children assessed prior to 1st January, 1963, how many were newly placed in special schools (other than hospital special schools) or boarding homes? ...	1	1	1	—	2	1	5	51	—	—	62
Total (B(i) and B(ii)) ...	1	1	3	1	8	14	16	69	1	—	114

On 23rd January, 1964, how many handicapped pupils from the Authority's area—

C. (i) were requiring places in special schools—											
(a) day ...	—	—	—	—	—	1	—	87	—	—	88
(b) boarding ...	—	—	—	—	1	1	7	121	—	—	130
(ii) included at (i) had not reached the age of 5 and were awaiting (a) day places ...	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places ...	—	—	—	—	—	—	—	—	—	—	—
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting—											
(a) day places ...	—	—	—	—	—	—	—	19	—	—	19
(b) boarding places ...	—	—	—	—	—	—	1	45	—	—	46
D. (i) were on the registers of											
1. maintained special schools as,											
(a) day pupils ...	—	—	—	—	21	29	—	125	—	—	175
(b) boarding pupils ...	—	9	1	4	2	—	4	90	—	—	110
2. non-maintained special schools as,											
(a) day pupils ...	—	—	—	—	—	—	—	—	—	—	—
(b) boarding pupils ...	7	5	11	3	4	11	2	5	4	—	52
Total ...	7	14	12	7	27	40	6	220	4	—	337
(ii) were on the registers of independent schools under arrangements made by the Authority	—	—	1	—	2	—	6	—	—	—	9
(iii) were boarded in homes and not already included under (i) and (ii) above ...	—	—	—	—	2	—	21	—	—	—	23
Total (D(i), (ii) and (iii)) ...	7	14	13	7	31	40	33	220	4	—	369
E. On 23rd January, 1964, how many handicapped pupils (irrespective of the areas to which they belong) were being educated under arrangements made by the Authority in accordance with Section 56 of the Education Act, 1944											
(i) in hospitals ...	—	—	—	—	—	—	—	—	—	—	—
(ii) in other groups (e.g. units for spastics, convalescent homes)	—	—	—	—	—	—	—	—	—	—	—
(iii) at home ...	—	—	—	—	4	—	—	—	—	—	4

TABLE VII
School Eye Clinics

<i>Centre</i>	<i>No. Clinic Sessions Held</i>	<i>No. Old Cases</i>	<i>No. New Cases</i>	<i>Total Seen</i>
Corby Nuffield Diagnostic Centre	64	254	198	452
Daventry Secondary School	13	89	56	145
Kettering School Lane Clinic	42	555	160	715
Northampton Guildhall Road Clinic	39	268	173	441
Rushden Memorial Hospital	25	274	106	380
Towcester Secondary School	7	50	26	76
Wellingborough Oxford Street Clinic...	39	321	122	443
	229 (239)	1811 (1875)	841 (662)	2652 (2537)
The figures in brackets refer to 1962.				
Brackley Cottage Hospital	4	25	16	41
Banbury Horton General Hospital	7	13	13	26
Total	240	1849	870	2719

TABLE VIII
Eye Diseases, defective vision and squint

	<i>Number of cases known to have been dealt with</i>
External and other, excluding errors of refraction and squint	—
Errors of refraction (including squint)	2719
Total	2719
Number of pupils for whom spectacles were pre- scribed	1332

TABLE IX
Orthopaedic and postural defects

	<i>Number of cases known to have been treated</i>
(a) Pupils treated at clinics or out-patient depart- ments	679
(b) Pupils treated at school for postural defects ...	37
Total	716

TABLE X
Diseases and defects of ear, nose and throat

					<i>Number of cases known to have been dealt with</i>
Received operative treatment					
(a) for diseases of the ear	...	...	...	...	—
(b) for adenoids and chronic tonsillitis	...	...	...	...	564
(c) for other nose and throat conditions	...	...	...	...	—
Received other forms of treatment	...	...	...	...	1
Total	...	...	...	...	565
Total number of pupils in schools who are known to have been provided with hearing aids					
(a) in 1963	...	...	...	...	8
(b) in previous years	...	...	...	...	31

TABLE XI
Infestation with Vermin

(i) Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	3,532
(ii) Total number of individual pupils found to be infested	76
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	Nil
(iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	Nil

TABLE XII
Diseases of the Skin
(Excluding uncleanliness, for which see Table XI)

					<i>Number of cases known to have been treated</i>
Ringworm—(i) Scalp	...	...	...	...	—
(ii) Body	...	...	...	...	—
Scabies	...	...	...	...	3
Impetigo	...	...	...	...	—
Other skin diseases	...	...	...	...	7
Total	...	...	...	...	10

TABLE XIII
Dental Inspection and Treatment

(a) Dental and Orthodontic work :									
(1) Number of pupils inspected by the Authority's Dental Officers :									
(i) At Periodic Inspections	...	...	...	...	...	...	...	...	20540
(ii) As Specials	...	...	...	...	...	...	...	...	2312
Total (1)									22852
(2) Number found to require treatment	...	...	...	...	...	...	...	...	15977
(3) Number offered treatment	...	...	...	...	...	...	...	...	13002
(4) Number actually treated	...	...	...	...	...	...	...	...	6913
(b) Dental work (other than orthodontics)									
(1) Number of attendances made by pupils for treatment, excluding those recorded									
at (c) (i) below	...	...	...	...	...	...	...	...	20299
(2) Half days devoted to :									
(i) Periodic (School) Inspections	...	...	...	...	...	...	...	...	174
(ii) Treatment	...	...	...	...	...	...	...	...	*2704
Total (2)									2878
(3) Fillings :									
(i) Permanent Teeth	...	...	...	...	...	...	...	...	10255
(ii) Temporary Teeth	...	...	...	...	...	...	...	...	2701
Total (3)									12956
(4) Number of teeth filled :									
(i) Permanent Teeth	...	...	...	...	...	...	...	...	9060
(ii) Temporary Teeth	...	...	...	...	...	...	...	...	2329
Total (4)									11389
(5) Extractions :									
(i) Permanent Teeth	...	...	...	...	...	...	...	...	2704
(ii) Temporary Teeth	...	...	...	...	...	...	...	...	6026
Total (5)									8730
(6) (i) Number of general anæsthetics given for extractions									
(ii) Number of half days devoted to the administration of general	...	...	...	...	...	...	...	...	3775
anæsthetics by :									
(a) Dentists	...	...	...	...	...	...	...	...	182
(b) Medical Practitioners	...	...	...	...	...	...	...	...	177
Total (6)									359
(7) Number of pupils supplied with artificial teeth	...	...	...	...	...	...	...	...	87
(8) Other operations :									
(i) Crowns	...	...	...	...	...	...	...	...	34
(ii) Inlays	...	...	...	...	...	...	...	...	11
(iii) Other Treatment	...	...	...	...	...	...	...	...	5457
Total (8)									5502
(c) Orthodontics:									
(i) Number of attendances made by pupils for orthodontic treatment	...	...	...	...	...	...	...	...	1786
(ii) Half days devoted to orthodontic treatment	...	...	...	...	...	...	...	...	203
(iii) Cases commenced during the year	...	...	...	...	...	...	...	...	192
(iv) Cases brought forward from the previous year...	...	...	...	...	...	...	...	...	195
(v) Cases completed during the year	...	...	...	...	...	...	...	...	116
(vi) Cases discontinued during the year	...	...	...	...	...	...	...	...	11
(vii) Number of pupils treated by means of appliances	...	...	...	...	...	...	...	...	246
(viii) Number of removable appliances fitted	...	...	...	...	...	...	...	...	246
(ix) Number of fixed appliances fitted	...	...	...	...	...	...	...	...	21
(x) Cases referred to and treated by Hospital Orthodontists	...	...	...	...	...	...	...	...	7

* Expectant and nursing mothers and children under five were also treated at these sessions.

TABLE XIV
Child Guidance Clinic

	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
No. of cases referred during year	112	63	175
No. of cases waiting to be seen on January 1st,	25	11	36
No. of cases seen by Psychologist and Psychiatrist	39	28	67
No. of cases seen by Psychiatrist only (including cases referred by Psychologist)	30	7	37
No. of cases seen by Psychologist only	4	1	5
No. of cases not seen	12	3	15
No. of cases waiting to be seen on December 31st,	52	35	87
Cases under psychotherapeutical treatment on January 1st,	92	46	138
New cases taken on for psychotherapeutical treatment during year	55	24	79
No. under psychotherapeutical treatment on December 31st,	112	46	158
Psychotherapeutical cases discharged during year	35	24	59
Cases waiting psychotherapeutical treatment on December 31st,	—	—	—
REFERRED BY :			
Parents	8	1	9
Head Teachers	11	6	17
School Medical Officers	12	7	19
Chief Education Officer	1	1	2
Family Doctors	28	12	40
Hospital Consultants	6	8	14
Health Visitors	8	3	11
Children's Officer	7	3	10
Magistrates and Probation Officers	8	7	15
Others	23	15	38
REFERRED FOR :			
Nervous Disorders	12	5	17
Habit Disorders.....	18	10	28
Behaviour Disorders	74	45	119
Organic Disorders	—	—	—
Psychotic Disorders	1	—	1
Educational Difficulties	7	3	10
No. of children discharged from Holyrood Hostel during year			8
No. of children admitted to Holyrood Hostel			10
No. of children removed by parents			1
No. of children discharged from Rostrevor Hostel during year			5
No. of children admitted to Rostrevor Hostel			5
No. of children removed by parents			2
No. of children in Residential Schools for Maladjusted Children			9

CLINICS ATTENDED BY SCHOOL CHILDREN

DENTAL

Corby—Pen Green Lane
 Kettering—Stockburn Memorial Home
 Northampton—Guildhall Road
 Rushden—Rectory Road
 Wellingborough—Oxford Street

REFRACTIONS

Corby—Diagnostic Centre
 Kettering—School Lane
 Northampton—Guildhall Road
 Rushden—Memorial Hospital
 Wellingborough—Oxford Street
 Daventry—Secondary School
 Towcester—Secondary School

VACCINATION AND IMMUNISATION

Corby—Pen Green Lane
 Kettering—School Lane
 Northampton—Guildhall Road
 Rushden—Rectory Road
 Wellingborough—Oxford Street

AUDIOLOGY

Kettering—Stockburn Memorial Home
 Northampton—Guildhall Road
 Rushden—Rectory Road
 Wellingborough—Oxford Street

The needs of children in the rural parts of the County were catered for by hiring suitable rooms for occasional assessment clinics.

ENURESIS

Corby—Pen Green Lane
 Daventry—Secondary School

CHILD GUIDANCE

Kettering—School Lane
 Northampton—28, Billing Road
 Wellingborough—Oxford Street
 Corby—Pen Green Lane

EAR, NOSE AND THROAT

Corby—Diagnostic Centre
 Kettering—General Hospital
 Northampton—General Hospital
 Rushden—Memorial Hospital

SPEECH THERAPY

Kettering—Stockburn Memorial Home
 Wellingborough—Park Hospital
 Corby—Ambulance Station
 Diagnostic Centre
 Northampton—Guildhall Road
 Wellingborough—Oxford Street
 Rushden—Rectory Road
 Oundle—Glaphorn Road Hospital

SCHOOL CLINICS

The Authority's mobile medical and two mobile dental clinics are used in certain parts of the County.

APPENDIX

Article by Principal School Medical Officer from "Balance" (1963 ; Vol. 10 ; p. 372), the Journal of the British Diabetic Association, reprinted by kind permission of the Editor

DIABETIC SCHOOLCHILDREN

While diabetes can occur at any age, it is commonest in those who are middle-aged or elderly. On the other hand, the younger a person is when he or she develops diabetes, the more care is required if adequate control is to be achieved. This is particularly true of diabetic children because, at their age, insulin is almost invariably required, and it is important that they should attain an adequate understanding of their condition in order that they may be able to look after themselves, not merely throughout their early years, but for the whole of their lives.

The care of the individual diabetic child must always be primarily a matter for the diabetic specialist and the family doctor, and this article is an attempt to deal with some of the questions which parents ask concerning the school life of their diabetic children. It must be remembered that, between the ages of 5 and at least 15, such children will spend the major part of their waking hours at school, and throughout Britain there are many hundreds of diabetic schoolchildren. Having regard, however, to the very large total number of children in schools in this country, it usually happens that, at any given school, there is not more than one diabetic child. This sometimes makes that boy or girl feel rather lonely and different from the others, and for that reason it is particularly desirable that every effort should be made to let the child live as normal a school life as possible, and this can usually be easily achieved.

The first question which tends to arise in diabetic children is their arrangements for meals during school hours. In towns, the majority can usually go home for their lunches, but domestic circumstances sometimes make this impossible and, in country districts, it cannot always be arranged because of the distances involved. In cases like these, an approach should be made to the school meals service through the school doctor. This service provides lunches at schools either from a central kitchen from which the food is distributed to individual schools in heated containers, or from the school's own kitchen. In either case, it is usually possible to adjust the feeding arrangements so that the diabetic child can receive an appropriate midday meal. This can be done by modifying the main course, for example by increasing the amount of green vegetables and cutting down the quantity of potatoes, and then by substituting either fresh fruit or cheese and biscuits for the sweet course.

As far as scholastic work is concerned, there is no difference between diabetic and other children, and there is no reason to believe that their intelligence is in any way different from that of the general school population. It is, of course, essential that the head master and the teachers should know that the child is diabetic so that in the event of any hypoglycæmic episode they will know what to do. It need hardly be added that the children themselves should carry a supply of glucose or sugar with them at all times. As parents will know, the commonest time for symptoms of hypoglycæmia to develop is shortly before a meal is due, and it is therefore important to let the teachers know that the child should have the midday meal at the same time each day. In some schools this meal has to be eaten in shifts and, in that event, arrangements will usually have to be made for the diabetic child to join the same shift each day, irrespective of what may happen as far as his classmates are concerned.

Individual school teachers do not see many diabetic children, and it is accordingly an advantage if they have the opportunity of discussing the child both with the parents and with the school doctor. In particular, it should be emphasised to teachers that, if the child shows any

untoward symptoms, these should be assumed to be due to hypoglycæmia and should be treated promptly by giving carbohydrate. There is a popular misconception that, if a mistake in diagnosing the cause of the symptoms is made, then there is a danger of causing diabetic coma by the giving of sugar. This is not, in fact, a hazard and teachers should be assured that the golden rule among diabetic children is "When in doubt, give sugar". For those children who require a mid-morning snack, this can usually be arranged at the time when the class is given its school milk ; but once again if some adjustment in timing has to be made, the teachers can make the necessary arrangements.

An important part of school life is physical education and diabetic children should always take part in it. The only difficulty which may arise is if the period devoted to games and physical education occurs shortly before a meal is due. In such an instance there is always the possibility that the physical activity may use up so much of the body's sugar supplies that symptoms of hypoglycæmia may appear. This can usually be overcome by arranging to take a suitable snack before the physical education is due, but in the majority of cases children are adequately covered by their breakfasts or by their mid-morning milk and snack. Should there, however, be any difficulty as far as physical education is concerned, then parents should consult their medical advisers before speaking to the school staff. There are only two forms of physical activity which may require a little extra care, and these are swimming and high apparatus work. It is desirable that the diabetic child should be able to take part in both of these, but it is as well to consult the doctor in charge of the case before permitting it. As far as swimming is concerned, the child should never swim unaccompanied.

It is understandable that the parents of a diabetic child, particularly if he is very young, will feel especially protective towards him. They must, however, try to realize that the best form of kindness is to help the child to attain independence and to accept responsibilities, particularly for his own diabetic care. By the age of seven, children should be able to give their own injections, and parents must try to find a middle way between indulgence and over-rigid discipline. It is particularly desirable that the children should not come to use their diabetes as an excuse for avoiding awkward situations, and here the parents' co-operation with the school teacher is all-important. In this connection, it might be worth mentioning that sometimes an early symptom of hypoglycæmia in a diabetic child is irritability and naughtiness. This does not mean that every diabetic child who is irritable or naughty is suffering from hypoglycæmia, but in a proportion this can be the cause, particularly at a time when a meal is due. The prompt administration of carbohydrate will restore things to normal in a matter of minutes.

Reference has already been made to the desirability of letting the School Medical Officer know about various aspects of the child's diabetes. In state schools children are usually examined three times in the course of their school lives. During these examinations, the fact that a child had developed diabetes would, of course, come to light ; but should the condition develop in the years between examinations, there is always the danger that the school medical service will not get to know about it. This would be most unfortunate and for that reason it is suggested that parents should always tell their child's teacher as soon as diabetes develops and should, at the same time, request the teacher to inform the Principal School Medical Officer. They should also let the physician at the diabetic clinic know where their child goes to school, as in many cases, arrangements are made for a copy of all clinic letters to be passed on to the school doctor.

Quite apart from the general supervision of the diabetic child, there are several special facilities which the School Medical Officer can provide. The first is protection against tuberculosis by means of B.C.G. vaccination. Diabetic children are more susceptible to tuberculosis than others but, by vaccination, they can be efficiently guarded against the disease. Sometimes this is looked after at the diabetic clinic, but where it is not, it is important that the child should

be vaccinated by the School Medical Officer without waiting until the age of 13, which is the usual age for vaccinating other children.

Another aspect of diabetic care in children is regular attention to their teeth. It is doubtful if diabetics are more susceptible to dental decay than others, but should decay occur and progress to a dental abscess, the state of diabetic control can be sadly upset and, here again, prevention is better than cure. It may be that the child has his own private dentist whom he attends regularly for inspection and treatment but, if he makes use of the school dental service, arrangements should be made for him to receive priority.

Very occasionally the diabetic child experiences difficulties which make education in the local schools unsuitable and, where this occurs, the education authority has the duty to help. There are several hostels which specialise in the care of diabetic children and, if need be, arrangements can be made for a child to live in one of these during term, returning home for the usual school holidays. This service is supplied without cost to the parents if the Principal School Medical Officer considers it to be necessary.

Readers of "Balance" need hardly be reminded about the availability of holiday camps for diabetic children. These are sponsored by the British Diabetic Association and cater for all age-groups and needs. They are an excellent means of helping the child towards independence and every diabetic child should be given the advantage of such an experience. Once again, if a suitable approach is made through the Principal School Medical Officer, most local education authorities will help towards all or part of the cost of such a holiday.

The object of all education is to prepare the child for his or her future life and, in the case of diabetic children, it is particularly desirable that thought should be given to their future careers at a relatively early stage in order that they may be prepared for the type of job which is best suited to their mental and physical abilities. Once again, this calls for co-operation between the family doctor, the consultant at the diabetic clinic, the School Medical Officer, the head master and his staff, the Youth Employment Officer and the child's parents. Nowadays young diabetics can look forward to healthy and active lives; by taking early steps to guide their careers into suitable paths, their lives can be made the more fruitful.

J.J.A.R.

